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CONTENTS.

CLINICS.

CLINICAL LECTURES.

Abstract of a Clinical Lecture on a Case of Abscess of the Tibia. By WILLIAM S. SAVORY, F.R.S., Surgeon to St. Bartholomew's Hospital, London.

Let us consider for a few minutes the case of abscess in the tibia, which is still in Abernethy ward. Ever since Brodie first called attention to this disease—now more than forty years ago—it has always been of striking interest, inasmuch as surgery, by a very simple operation comparatively free from risk, can not only afford sudden and complete relief from excruciating pain, but can avert the gravest evils—the loss of limb or life. In the diagnosis too, although a high degree of probability may usually be reached, yet an amount of uncertainty must always remain, sufficient to cause the steps of the operation itself to be watched with the keenest anxiety; and the surgeon can hardly know a moment of greater pleasure than when he sees pus ooze up through his incision in the bone: it is doubly welcome, for it is at once evidence of a correct diagnosis and the guarantee of a successful operation.

T. I——, twenty-one years old, very much under the usual size and still bearing the marks of old rickets, was admitted into the hospital on the 17th December, 1873, with the following history: That four years ago he had first noticed swell-

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ing of the leg. The swelling was accompanied with much pain, especially at night. For some time after it was first noticed it increased very gradually in size. It then became stationary. The pain had subsided after the first onset of the disease, and had even been for a long time absent, or only occurred at occasional intervals. During the few months previous to admission it had again become more frequent, and for about a month had been at times unbearable. On being closely questioned, he remembered, having been struck on the leg with a cricket-ball seven years ago, but there was no history of injury of more recent date.

On admission, there was a smooth, hard swelling of the left tibia about the junction of the upper and middle third. The limb at this point measured about an inch more than its fellow at the same level. The swelling rose gradually from the normal surface of the bone, and sank as gradually below into it again; it was tender, especially about its summit, and the skin covering it was mottled with a bright pink colour, was partially adherent to the periosteum, and somewhat puffy. He complained of excessive aching pain in the bone—pain which was seldom absent, but which was peculiarly severe at night. Iodide of potassium in three-grain doses was ordered, and the case was carefully watched. During the first few days he obtained very little sleep, only dozing for a few hours after morphia or opium. The morning temperature was little above the normal, the evening temperature from 100° to 101°. Leeches were applied, and the quantity of morphia increased, but with only slight temporary relief.

As the pain continued, and the loss of sleep began to tell upon his general health, I determined to cut down upon the bone, and if necessary to trephine it. Many of you were present at the operation on the 28th of January, when I made a longitudinal incision over the summit of the swelling, through the skin and thickened periosteum, and then with a small saw made a similar incision through the wall of the bone itself. You saw how suddenly pus welled up through the wound, and that then a small trephine was applied and a portion of bone removed. An abscess cavity, perfectly circumscribed, was thus opened, containing about six or eight drachms of laudable pus, lined, as one could feel with the finger, by a smooth velvety surface, and measuring some three inches in length. The pus was evacuated, and a small strip of oiled lint was inserted into the wound. During the first day or two after the operation the patient complained of pain almost as severe as before; but the pain gradually passed off after the removal of the dressings and the application of a poultice. From that time his course has been uninterruptedly good; his temperature has been normal; his appetite has improved; he has slept well. The discharge is gradually diminishing, and the wound is slowly closing.

Such an abscess as this is the result of chronic inflammation of the bone, generally attacking the cancellous tissue. A circumscribed abscess in formed, usually of small size, close to one of the articular ends of the bone. This specimen[1] exhibits well the characters of such a cavity. You see its interior is lined with a thick "pyogenic" membrane, now partially detached. The wall of the bone is not materially increased in size, but the articular end is enlarged, and the periosteum is thickened. The tibia is far more often affected than any other bone, but the ribs, sternum, clavicle, humerus, and femur may also be the seat of abscess. It is not every chronic inflammation, however, which leads to the formation of a circumscribed abscess. If you look at the specimens in the museum you will find comparatively few such abscesses, whilst the shelves are richly furnished with other results of slow inflammation. These specimens[2] are admirable examples of such changes. In the former the cortical portion of the shaft of the tibia is not only considerably thickened, but it is indurated by interstitial formation of new bone. The periosteum is thickened and new bone is produced between it and the shaft of the bone it covers. In the second specimen there is not only induration of the cortex, but the change

[1] Series I., 82. [2] Series I., 53 and 131.

has affected the medulla also, so that at certain points no medullary cavity remains. Between these points there is diffuse suppuration in the interior of the bone, whilst here and there are small openings which communicate with the surface. I need scarcely mention caries and necrosis as the results of chronic inflammation, for scarcely a day passes but those who are in the surgical wards or operating theatre have the opportunity of observing such cases. Occasionally, however, it happens that abscess is combined with one or other of these conditions, of which you cannot have a better example than this,[1] where in an abscess cavity in the upper end of the tibia, precisely similar in all respects to other abscess cavities in bone, lies a small sequestrum about the size of a nut, and perfectly loose. Contrast for a moment the effects of chronic with those produced by acute inflammation. Look at the diffuse suppuration of the medulla after an amputation through the bone, rapidly affecting the whole of the interior of the shaft; or at the inflammation of the surface, leading quickly to the formation of pus between the bone and periosteum, and later to necrosis of the whole or a portion of the shaft. Occasionally there is great difficulty in diagnosing between the effects of chronic inflammation and necrosis. In a previous paper[2] I pointed out this difficulty, and also how it may be avoided—how in chronic ulceration and induration of bone small flakes of necrosed bone often lie at the bottom of the fistulous canals, leading down to its surface, and how, by keeping in the line of such tracks, these small flakes are detected and removed, and the disease is thus relieved. There is still one cause of abscess in bone which I have not mentioned—tubercle. You know how this often occurs in or near the articular ends of bones, how it occasionally breaks down and forms a puriform fluid which may be contained in an irregular cavity in the bone, or how it sometimes, as in this specimen,[3] ulcerates into a neighbouring joint. But the abscess thus formed is much more insidious than the simple abscess we are discussing; it seldom gives rise to redness of the skin, or to abiding and severe pain.

In our diagnosis of the disease we are guided by the following points, and you will see how the case before us bears them out. The affection almost always occurs in young subjects, either in children or in young adults. The age of the oldest patient mentioned by Brodie was thirty-four years; but, whilst his age was exceptionable, he serves well to illustrate the second point in connection with the disease. Its duration is said to have been no less than eighteen years, and although this is perhaps the longest case on record, still we find that these cases are generally to be measured by years. Pain is a constant symptom, generally of a dull aching or throbbing character, and especially severe at night. Strangely enough, sometimes apparently as the result of treatment, but often spontaneously, the pain diminishes, or may even cease entirely. But, unless the disease be relieved, it will surely return, and is then generally more severe than before. Exercise or pressure upon the part causes increase of the pain, and is particularly likely to produce its renewal after long remission. The bone at the seat of disease is often considerably enlarged, and its enlargement is due to more than one cause. The collection of pus in the interior produces an actual stretching of the bony wall in spite of its hardness—a fact sufficient at once to account for the force with which the pus wells up after incision has been made, and for the character and intensity of the pain. At the same time there occurs a new formation of bone beneath the periosteum. In some cases this is more marked, in others it is scarcely noticeable, but it is seldom, perhaps never, entirely absent. Tenderness is often a prominent symptom—general tenderness over the whole area of the diseased part—and, in addition to this, more acute and abiding tenderness at some one spot, so that when the finger is applied firmly over this the patient flinches or cries out. The swelling of the part is still further increased by the tumefaction which the soft parts undergo, and by the well-marked thickening of the peri-

[1] Series i., 305.
[2] The Lancet, vol. i. 1864, p. 433.
[3] Series i., 70.

osteum. The integuments are puffy as well as swollen, often pitting slightly on pressure, whilst the skin is often covered, as in this case, by a faint pink blush or mottling, although occasionally it is even paler than normal.

Supposing such a case be not relieved, what should we expect to be the consequence? Why, after many months or even years of suffering, during which the neighbouring joint is not uncommonly the seat of occasional attacks of inflammation, subsiding under rest, but recurring after exercise, and causing continual anxiety for their ultimate result, the matter at length may make its way to the surface, as in an ordinary abscess. Fistulous passages form through the bone and the soft parts, and the pus is discharged; or, far worse, the pus makes its way into the neighbouring joint, and as a consequence, there ensues complete and rapid destruction of it. This specimen[1] is an example of such a catastrophe. The upper end of the bone is hollowed out and worm eaten. The articular cartilages are almost absent. A large opening into the joint exists between them. Unless relieved by amputation, or even after operation, the patient may perish, exhausted by the protracted struggle.

The obvious treatment of abscess of the bone is, of course, to let the matter out. The operation always practised is to cut down upon the bone, turn back the periosteum, and with a small trephine to remove a circle of bone, and thus give exit to the pus. Even supposing that the diagnosis be at fault, that there be no circumscribed abscess, yet the operation is likely to prove beneficial. The disease most liable to be mistaken for abscess is chronic inflammation; and for this condition, when obstinate, as for abscess, the best treatment is to incise the bone. Here, as in similar disease of soft parts, such an incision relieves tension, draws blood from the part, and acts as a drain for the removal of other fluids. By these means pain is relieved more certainly than by any other.

I have chosen this case as a striking illustration of the disease. Its long duration, the age of the patient, the continuous pain increased at night, the appearance of the part, all combine to make it a typical example. Yet there are certain points in which it differs from such cases generally, and not the least important of these is the position of the abscess. This lay, as you noticed, not close to the articular extremity of the bone, but about the junction of the upper and middle third. Again, too, the size of the abscess was much greater than is usually found. It appeared to be about three inches long, and contained from six to eight drachms of pus.

I employed a mode of operating somewhat different from that commonly practised. Instead of trephining immediately, I made a longitudinal incision in the bone with a small saw, and it was not until pus oozed up through the wound that I used the trephine. This appeared to me a simpler operation than trephining; it was likely to give great relief in case there should be only chronic inflammation; and it gave a much wider range, and consequently an increased probability of finding pus if any were present. For you know it has happened that a small abscess has just been missed by the trephine, a mistake discovered only after the amputation of a limb, which might have been saved by so simple an operation.—*Lancet*, June 6th, 1874.

[1] Series I., 163.

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Fetid Bronchitis.—Prof. Sée, in some clinical remarks at the Charité Hospital, called attention to a woman suffering from phthisis, in whom the expectoration was extremely fetid. M. Sée, after expatiating upon the supposed origin of fetid expectoration, stated that it is to be met with in the following conditions: Gangrene of the lungs, general or partial; Bronchial dilatation (bronchiectesis); Pulmonary phthisis; and lastly, Fetid bronchitis, or, as it is sometimes termed, Fetid bronchial catarrh. He then went through the differential diagnosis between the affection in question and those just named. In the case of the patient under notice, the supposition of pulmonary gangrene is out of the question, as no cavity could be detected either by auscultation

or percussion. On auscultation, large movable râles (*râles mobiles*), can be heard all over the lungs on both sides, and in front; at the back, a slight diminution of sonority is noticed equally on both sides; moreover, the left side presents a certain degree of dulness, and râles of a fixed character are heard in the supra-spinal regions. These physical signs would indicate the presence of cavities in a rudimentary state (*cavernules*). The idea of bronchial dilatation cannot be entertained, as no "souffle" can be heard either to the right or to the left. M. Sée believed the patient was affected with fetid bronchitis, complicated with tuberculosis, as about a year ago she had an attack of hæmoptysis, which would favour the idea of tuberculosis, although not absolutely so, as pulmonary hemorrhage may likewise take place in fetid bronchitis. The general state of the patient, the emaciation, the fever, with other signs in the summit of the left lung, would certainly point to tuberculosis.

Spinal Paralysis in Children.—As an example of this affection, Prof. Sée presented a young girl, about 8 years old, who was an out-patient, at the Charité Hospital, Paris, and took occasion to make a few cursory remarks *apropos* of the case. He stated that, in general, the malady announces itself by the following symptoms: agitation, convulsions, the patient becoming insensible, and fever, with or without vomiting, though in the cases previously met with by M. Sée, he had not noticed any fever. In the present case, however, the malady was ushered in by fever. The next point to be noticed in this affection is the state of partial paralysis; only *one* limb is affected, and this may be the left or the right; although some authors have observed the hemiplegic form (leg and arm); also paralysis of the two inferior members, without cerebral disorder. A third point to be considered is the loss of electro-muscular excitability. This is in relation with the number of fibres affected; all the fibres are not necessarily implicated; in this case, the prognosis is favourable, and the return, more or less complete, of this property may be hoped for. Fourthly, sensibility is not in the least affected. Fifthly, the bladder and rectum are always intact. Lastly, infantile paralysis constantly results in atrophy, and which extends to the skin, to the adipose layer, and not only to the muscles, but to all the parts of the limbs, to the tissues, and even to the bones. The development of the osseous system is backward; the diameter or the circumference of the diseased bone, and its length, are much less than that of the healthy bone. All these were well characterized in the patient that elicited these observations. About three years ago, a slight amelioration was noticed in the child; the limb appeared to assume a certain degree of development. The word "atrophy," according to Prof. Sée, is not quite correct as applied to these cases; it is better, he adds, to substitute "defect of atrophy." In this child all confusion of diagnosis is impossible, particularly with paraplegia; or with cerebral affection; or with myelitis, properly so called; or paralysis, dependent on nervous convulsions. From the shortening of the limb, it might have been confounded with coxalgia; in the present case, the shortening of the limb is due to an arrest of development; as for the pain experienced, this is extremely rare in essential paralysis of childhood. With regard to treatment, M. Sée has not seen any great advantage derived from drugs; diet and regimen may be of some service, but speaking generally, he considers the disease as beyond the reach of art. Electricity, it is stated, has effected some cures, but these, to say the least, are problematical.—*Irish Hospital Gaz.*, July 1, 1874.

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White Piles.—Prof. Richet delivered, at the Hôtel-Dieu, a very interesting lecture on what he termed "white piles" (*hæmorrhoïdes blanches*), which he uses in contradistinction to bleeding piles, as in the former, instead of a discharge of blood, this is transformed into a sero-mucous fluid, secreted by the diseased parts. After describing the morbid anatomy of external piles, the worthy Professor stated, that white piles are merely ordinary piles in a more advanced stage, and consisted principally

of hypertrophy of the papillary bodies of the mucous membrane. Some medical men, he said, looked upon this condition of piles as less dangerous, or less pernicious to health. But this was a mistake, as the incessant discharge, which at times is so great as to flow down the patient's legs, must in the end act like long continued bleeding; for after all, mucus, like the other secretions of the body, whether normal or abnormal, is nothing more nor less than blood transformed. M. Richet selected this subject for his morning's clinque, *apropos* of a patient in his ward, who has been suffering from piles for the last thirty years. In this case bleeding has for some time given place to a sero-mucous discharge which has so drained the patient, and he is, moreover, so uncomfortable with the constant dripping, that he has asked to be relieved at any price. Excision, continued M. Richet, is the proper remedy for external piles; but, as this operation is attended with great danger, owing to the excessive hemorrhage that sometimes follows, he prefers removing them with hot irons, raised to a white heat. He does not approve of the galvano-caustic, as, while it has the advantage of rapidity of action, it has the great drawback attributed to cutting instruments, that of not preventing hemorrhage, as does Chassaignac's écraseur; or Maisonneuve's wire "constricteur." These latter, however, have the inconvenience of producing permanent constriction of the anus.—*Irish Hospital Gaz.*, July 1, 1874.

HOSPITAL NOTES AND GLEANINGS.

Emphysema occurring during Labour in a Case of Contracted "Flat" Pelvis.—The following case (*Lancet*, May 2, 1874) is worthy of record from the comparative rarity of the accident, and also as showing the mechanism of labour in the "flat" pelvis.

Ellen C——, single, aged twenty-three, a primipara, was admitted into Queen Charlotte's Lying-in Hospital on the evening of the 10th of December last, in labour. The "waters" had broken some time previously, and the patient had had a severe shivering attack about the same time. Was delivered, at 10.20 P. M., on the 11th, of a female child weighing 9¾ lb. The first stage lasted forty hours, the second six hours. During the latter stage the pains were very strong, and the expulsive efforts extremely violent. The head, which was the presenting part, did not advance until the patient was placed on her hands and knees, after which the labour made rapid progress, and she was delivered in that position. The placenta came away in twenty minutes. Two hours afterwards there was flooding, which was with difficulty arrested. She experinced no difficulty in breathing, nor was she conscious that anything had happened to her chest during the labour. She stated that she had always had most excellent health, and, with the exception of smallpox, had had no illness of any kind; no cough; family healthy; parents living. Had fretted much whilst "carrying" the child, and during the last two months had vomited much.

Next day she complained of sore-throat, and on examination of the cervical region emphysematous crackling was discovered extending over the face and the front of the neck, but more on the right side. The face was puffed. No cough. Chest sounds normal.

On the 13th the emphysema had extended over the front of the chest, still keeping more to the right side. From the course and direction of the air, it appeared probable that the rupture of the air-cells had taken place in the right lung near its root; thence the air had escaped into the middle mediastinum, and ascended alongside of the trachea and the large vessels into the cellular tissue beneath the skin of the face, neck, and chest.

The sore-throat of which the patient complained was evidently dependent on the air diffused into the cellular tissue of the neighbourhood of the pharynx. The emphysematous crackling entirely disappeared in seven days. There was a considerable rise in temperature and in the frequency of the pulse during that period.

The child's head was remarkably flattened, and looked as if it had been com-

pressed between two boards, the fore and back part of the head were so equally projecting; very slight caput succedaneum; the plane of the sagittal suture was nearly horizontal; on either side of the head, reaching behind the ears, were raised red marks, similar to the impressions made by the blades of the forceps —in fact, they might have been easily mistaken for such. Over the occipital protuberance was a swollen red patch, which afterwards sloughed. No force was used to the head during its passage through the pelvis or outlet. The two former marks were evidently made by the head pressing against the sacral promontory and the symphysis pubis, the latter against the arch of the pubes. The pelvis was examined carefully later on, when there was found considerable flattening of sacral promontory and the body of the pubes, with shortening of the conjugate diameter of the inlet. The course and direction of the marks on the side of the head exactly corresponded with the description given by Spiegelberg in his paper on the "Mechanism of Labour in the Common Forms of Contracted Pelvis." The head enters the inlet in the transverse diameter, and the sagittal suture runs in a transvese direction and very near to the posterior wall. The head makes two rotations, one on the occipito-frontal axis, and the other upon its transverse axis. In order to facilitate this action, the force (when the head has been partially moulded) should be downwards and backwards. If the woman is placed on her hands and knees, the uterus falls forwards and the axis of the body of the child would form an angle, looking anteriorly with the axis of the head in the brim; consequently the head would rotate on its occipito-frontal axis, the sagittal suture coming forwards.

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Varicocele treated by the Elastic Ligature.—J. L., aged 22, was admitted into the Queen's Hospital, Birmingham, under the care of Mr. West, on May 3d, he having a varicocele of some weeks' duration. On the 9th the vein was ligatured with an elastic ligature by Mr. West. On the 14th the ligature had cut its way nearly out, and was then removed. The patient was discharged well on May 27th, the vein being obliterated by a firm clot, but no suppuration taking place during the progress of the case.

The elastic ligature has also been used in two cases of nævus by Mr. West and Mr. Wilders. In both cases the ligature came away on the fifth day, leaving a healthy granulating sore, and the children have been completely cured of the deformity caused by the nævi.—*Lancet*, July 4, 1874.

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Stricture of Rectum; Colotomy.—Mr. Jordan, at the end of April, at the Queen's Hospital, Birmingham, performed Amussat's operation in a case of obstruction of the rectum from cicatrization following extensive ulceration. The patient has made a most complete recovery. In a case of epithelioma of the anus and rectum, in which both ischio-rectal fossæ were filled with large indurated masses, the same gentleman removed about two inches of the lower end of the gut by means of two semilunar incisions commencing at the posterior wall of the vagina, passing close to the tubera ischii of either side, and meeting posteriorly behind the coccyx. The whole of the indurated mass was in that way removed. The extensive wound thus produced was much diminished by approximating its sides anteriorly and posteriorly by means of sutures. The gut was drawn down and loosely stitched to the margins of the opening. The patient is doing well.—*Lancet*, July 4, 1874.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Rötheln, or German Measles.—Dr. J. Lewis Smith reports (*Sanitarian*, July, 1874) that this rare disease is now prevailing in the city of New York. He has statistics of the disease as it appeared in twenty-one families, examining and treating the cases in eighteen of them. In the remaining three families the symptoms and histories were so fully and clearly described to him that he has not hesitated to accept the cases as genuine.

In the twenty-one families there were forty-eight cases.

Premonitory symptoms were absent or mild. In a considerable number of the cases it was not known that the patients were sick until the rash was observed covering the surface. Sometimes children preparing to go to school were observed to have the rash, although they had eaten their meals regularly, and complained of no ailment. In one or two instances they were sent from school because the teachers observed the rash, although they felt well enough to continue their lessons. Others were a little dull, or complained of nausea or slight headache from one to three days previously to the occurrence of the eruption. In one case only were there grave premonitory or initial symptoms, namely, in a boy of eight years, who had clonic convulsions.

The rash appeared first either along the back or chest, or upon the face or neck, and, as in measles, it extended downward, not appearing upon the legs till after some hours or on the following day. Its colour was most pronounced on the first day, after which it gradually faded, and by the close of the third day disappeared. The hue, especially after the first day, was usually a dusky red. The rash resembled more that of measles than of any other eruptive fever. In one case, a boy of three and a half years, it presented over the trunk very much the scarlatinous appearance. It commonly produced itching; disappeared on pressure, caused a little roughness, as ascertained by carrying the fingers over the surface, and faded without desquamation.

Occurring simultaneously with the dermatitis, there was a mild inflammation of the mucous membrane, covering the buccal, pharyngeal, and nasal surfaces, and of the reflection of this membrane over the eyes and eyelids, namely, the conjunctiva. This gave rise to sore throat, sneezing, sometimes a slight defluxion from the nostrils, suffused, watery, or reddish eyes, and, in certain cases, a puriform secretion collecting at the angles of the eyelids, and more or less usually slight œdema of the lids. In one case, an infant of 28 months, there was so much œdema coming on the second day that it was impossible to examine the eyes. This swelling declined in three or four days.

The febrile movement was ordinarily mild, the pulse in ten uncomplicated cases ranging from 80 to 100, and the temperature from 98⅘° to 100°. The appetite was impaired, but not lost; little or no thirst; little or no cough; bowels regular. A common symptom was nausea, and several of the patients vomited. The urine examined in two cases was found normal. The duration of the disease was only three or four days.

The incubative period did not seem to be uniform. In some instances it appeared to be from seven to ten days, and in others from eighteen to twenty-two days, varying, therefore, as in scarlet fever.

Dr. Smith concludes, from his observations, that this disease is a contagious exanthematous fever, allied to measles and scarlet fever, but totally distinct from either. It must be placed in the same category with them. Most cases more closely resemble measles than any other disease, but that there is a specific difference is evident from the fact that those who have had measles are as liable to this malady as those who have not had it. Nineteen at least of the forty-eight cases observed by Dr. Smith had had measles, and some of them only a few months previously. In the Catholic Foundling Asylum, in 68th Street, with which Dr. Smith is connected, measles prevailed as an extensive epidemic in February and March, and this was followed by an epidemic of the new disease, which commenced March 25th, and by the first of May had affected about thirty of the children and three nurses. Of these cases a large proportion had had measles.

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The Pathology of Insanity.—Dr. John P. Gray, Superintendent of the New York State Lunatic Asylum, has for several years past been engaged in pathological investigations, and more recently in

special microscopic work, and in the *American Journal of Insanity* for January last gives a brief summary of some points of interest.

He states that, although the cases thus far examined may be regarded as insufficient to establish general conclusions, they go to strengthen the conviction sustained by the laws of general pathology, that insanity is a physical disease of the brain, and that the mental phenomena are symptoms; further, that the microscope, with patient and close investigation, will continue to disclose structural changes in the cerebral tissue, as marked as those heretofore unsuspected, when examinations were limited to the scalpel and naked eye; and in these investigations, when the entire range of the disease, in every stage of its progress, shall have been brought under the microscope, we may be able to solve the problem of the morbid processes denominated insanity.

Another conclusion to which these investigations would naturally lead, is, that the variety and changes in the predominant symptoms of insanity may acknowledge their cause, not so much in the variety of lesions as in the special parts of the cerebral centres which are morbidly involved in each case; or, to bring the idea within narrower limits, that emotional, ideational, and motor disturbances, have their foundation in the extent and degree to which the nerve-elements that minister to the execution of intellectual and motor acts are involved in the lesion. When the disease reaches its ultimate stage, all distinctions cease, dementia being the same closing stage of every so-called form of insanity.

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Exstrophy of the Bladder.—In the report of operations performed at the Massachusetts General Hospital published in the *Boston Med. and Surg. Journ.* (June 25, 1874) are given the notes of a case of exstrophy of the bladder occurring in a boy nine years old. Immediately above the penis was a rounded, vascular swelling, covered with mucous membrane, and consisting of the protruded, posterior wall of the bladder; its protrusion varied with the amount of pressure from behind and with the respiratory movements. It was extremely sensitive, and constantly irritated by the contact of clothing. On one side, the testicle had descended, on the other it had not. On the former was a reducible, oblique, inguinal hernia. The open mouths of the ureters could be seen at the lower part of the swelling, and urine constantly dropped from them on the parts beneath. The umbilicus was wanting. An oblong square skin flap, two and one-half inches wide by three and one-half inches long, was dissected from the groin, scrotum, and lower part of the abdomen, leaving a broad pedicle bordering on the mucous surface described; the integumental surface of this flap was laid upon the mucous surface of the bladder, forming an anterior wall. To protect this raw surface, and provide for the lateral wall of the other side, a second skin flap was taken from the same region of the opposite side and laid upon it. The free borders of the flaps were stitched together by silver wire sutures. The raw surfaces left, from which the flaps were taken, were covered, as far as possible, by the adjoining integument, and the remainder left to granulate. Other steps to complete the result were contemplated when cicatrization had taken place.

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Practice of Medicine in Missouri.—At the last session of the General Assembly of the State of Missouri, a law was passed which makes it unlawful for any person to practise or attempt to practise medicine or surgery in this State without first receiving a diploma from some duly established college or university, and filing a copy of the same with the clerk of the county in which the practitioner resides.

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Kansas Medical Society.—At the annual meeting of the Kansas Medical Society, held at Lawrence, May 20 and 21, the following officers were elected for the ensuing year:—

President, Dr. J. S. Redfield, of Fort Scott. Vice Presidents, Drs. T. Sinks, of Leavenworth, and R. Morris, of Lawrence. Secretary, Dr. D. W. Stormont, of Topeka.

The next meeting will be held at Topeka, on the third Wednesday in May, 1875.

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Kentucky State Medical Society.—The officers elected for the year 1875 are as follows:—

President—Dr. J. Baker, of Shelbyville; *First Vice-president*—Dr. George Beeler, of Clinton; *Second Vice-president*—Dr. J. Y. Newkirk, of Bedford; *Recording Secretary*—Dr. J. A. Larrabee, of Louisville; *Corresponding Secretary*—Dr. B. F. Logan, of Shelbyville; *Librarian*—Dr. J. J. Speed, of Louisville; *Treasurer*—Dr. L. B. Todd, of Lexington; *Publishing Committee*—Drs. W. F. Owen, W. H. Galt, and R. H. Gale, of Louisville.

The next meeting of the society will be held April, 1875, at Henderson, Ky.

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Obituary Record.—Died, in Boston, on the 20th of June, aged 55, George Derby, M.D., Secretary of the State Board of Health of Massachusetts, and Professor of Hygiene in Harvard University.

Dr. Derby graduated in medicine at Harvard in 1843, and served with distinction as surgeon in the army during the late war. On the establishment of the Massachusets State Board of Health in 1869, he was appointed its Secretary, and how faithfully he discharged the laborious duties of his office our readers well know.

—— In Philadelphia, on the 2d of July, Gouverneur Emerson, M.D., aged 79 years.

Dr. Emerson is, perhaps, best known to the profession through his valuable statistics of mortality in Philadelphia, which appeared in the earlier volumes of the *American Journal of the Medical Sciences.* For a number of years he had retired from the practice of his profession, though always maintaining an interest in it, and devoted his time more particularly to scientific and practical agriculture. He was a man of general culture, and a valuable contributor to the literature of farming. Characterized by remarkable placidity, amiability, and unswerving integrity, with good natural abilities well cultivated, and liberal tastes, he was warmly esteemed by many appreciative friends, most of whom he survived.

FOREIGN INTELLIGENCE.

Warts upon the Margin of the Lid.—Although warts upon the margin of the lid may, in most cases, exist for years without giving any annoyance, yet two cases have lately occurred within a short period in Prof. v. Arlt's private practice, in which a wart that had rapidly grown upon the free margin of the lid, gave rise to an acute catarrh of the conjunctiva, without any direct mechanical irritation of the membrane. Prof. v. Arlt smiled at the suggestion of the patient, that the wart might be the cause of the conjunctivitis. Only after a lengthened treatment with various applications had proved fruitless, did he determine to snip off the wart, when, to his astonishment, he saw the conjunctivitis disappear in a few days. In the second case, which had been under treatment elsewhere for conjunctival catarrh without benefit, he proceeded at once to remove the wart, and obtained a rapid cure of the inflammation. To Arlt this experience was new, and it may be that the observation will be of use to other practitioners.—*Irish Hosp. Gaz.*, July 1, 1874.

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Amussat's Plan for the Ablation of Tumours by Means of the Thermic Galvano-Caustic Process.—Since 1852, M. Amussat has employed several plans for the ablation of tumours by means of the thermic galvano-cautery. He first pedicellated them with steel grooves, also intended to direct the course of the platinum wire; at a later stage he removed them with the galvanic *sécateur;* then with the platinum bistoury. Ablation with the *sécateur* is one of the most simple plans of operation, and the one to which M. Amussat generally has recourse. But when the tumours do not pedicellate well, the thread slips, and the section is not satisfactorily performed. To obviate this

inconvenience, M. Amussat places one or more ivory stems in the plane of the section, below which he makes the end of the thread pass before introducing them into the *sécateur*, and thus makes certain of the regularity of its action. In the case of a lady who had an ulcerated tumour in the internal portion of the mammary gland, one ivory stem was enough to guide the thread, and allow a very clean section of the tumour, without the least flow of blood. This very simple plan is applicable to tumours of all kinds which do not pedicellate sufficiently.—*London Med. Rec.*, July 1, 1874.

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Surgical Anæsthesia.—M. Fornes, a French naval surgeon, urges the advantage of putting a patient asleep by administering chloral hydrate previously to his inhaling chloroform for the purpose of anæsthesia.—*Le Mouvement Médical*, June 27, 1874.

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Foreign Body in the Male Urethra; Ingenious Extraction.—In the tenth number of the *Bulletin de Thérapeutique* (1873), Messrs. Andant and Lonstalot mention the case of a gentleman suffering from stricture, who was in the habit of passing an elastic catheter for himself. One day, through absence of mind or some other cause, he passed the instrument (No. 7) commencing by the end to which the bone ring is attached instead of the proper end supplied with the eye. After reaching the perineal region, he attempted to withdraw the catheter, but the latter returned without the ring, which had become detached and remained in the urethra. Dr. Andant was sent for and requested by the patient to push the ring into the bladder, as pain and a wish to pass water had supervened. At a consultation with Dr. Lonstalot it was resolved to use the following contrivance: A No. 7 catheter was obtained at a chemist's, and the bone ring being taken to a smith, an iron rod of the same diameter as No. 7 was chosen, one end of which was turned so as to act as a screw, fitting the grooves of the bone ring. The instrument was put into the hands of the patient, because, by long practice, he had learned the peculiarities of his urethra. Dr. Andant had, however, previously introduced a silver catheter with great caution, and ascertained the presence of the bone ring in the urethra. The patient was directed, when reaching the ring, to roll the free end of the rod in his fingers, so as to introduce the male screw into the ring. This was very cautiously and cleverly done, and when it was supposed that the rod was sufficiently fixed, it was slowly withdrawn, and the ring was brought to light, to the great satisfaction of both the patient and the surgeons.—*Lancet*, May 23, 1874.

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Hæmorrhoids.—Dr. William Colles, of Steevens's Hospital, Dublin, has lately suggested treating hæmorrhoids by injecting the tincture of the perchloride of iron. He had some time since a case of internal hæmorrhoids under his care, and used this method, twenty minims being injected into each hæmorrhoidal tumour; and on the rectum being explored by a speculum some weeks afterwards, no traces of the piles could be discovered except a few nodules of cuticle, each of the size of a shrivelled currant. The case had been previously treated without avail by the application of fuming nitric acid, a remedy first suggested by the late Dr. Houston of Dublin.—*Brit. Med. Journ.*, June 27, 1874.

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Treatment of Varcies by the Local Employment of Perchloride of Iron.—Dr. Linon, of Verviers, has used perchloride of iron locally with great success during the last three years in the treatment of varices. The strength of the solution is about two and a half drachms to eight ounces of water. Compresses of flannel are steeped in the water, then wrung out, and applied by means of a flannel bandage, which is only to be moderately tightened. This application is to be kept on twenty-four hours, and on removing it the surgeon is much surprised to find that the venous dilatations have almost entirely disappeared. The applications are to be renewed as above during seven or eight days successively, after which time the bandage is to be kept on, with-

out any further wetting, till it gets loose. It is then to be wetted again with the solution, and applied, until the varices have disappeared, which generally takes place after eight days or a fortnight, according to the size of the swelling. These simple means have removed in a few days enormous varices, accompanied by violent pain, with black spots on the surface, and have restored to the patients the use of their limbs. By the unsuccessful application of dry bandages only, Dr. Linon has been able to show that it is not compression, but really the local action of the iron which is efficacious. The local action of the thermal waters containing magnesia on the skin is similar to that of the perchloride. Thus at Luxeuil patients affected with varices derive great benefit from the Benedictine pond. — *Lancet*, June 6, 1874.

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Camphor in Erysipelas.—M. Revillout states (*Gaz. des Hôpitaux*, June 20) that he has several times had occasion to employ with good result in erysipelas an application used by M. Delpech at the Necker. It consists in painting the affected surface with a solution of camphor in ether (equal weights); and when this is employed in erysipelas of the face, and the affection has not yet reached the hairy scalp, its progress is usually arrested. It is also very useful in erythema caused by local irritation.—*Med. Times and Gaz.*, June 27, 1874.

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Prurigo and Ulcerations in Variola.—Dr. Guéneau de Mussy recommends (*Ann. de Dermat.*, 1874, No. 3) the following pomade when the itching in variola is excessive: Cerate thirty grammes, bromide of potassium three grammes, and camphor three decigrammes. When the pustules are followed by ulcerations, he prescribes the following pomade: Cerate thirty grammes, tannin, oxide of zinc, of each two grammes, calomel two decigrammes, and watery extract of opium one decigramme.—*Med. Times and Gaz.*, May 9, 1874.

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Chloral in Trismus and Tetanus of Newborn Children.—D. A. von Huttenbrenner (*Jahrb. d. Kinderheilk.*, H. 1, 1873) has made a trial of chloral hydrate in the above cases, and, on the strength of his own experience, added to that of Steiner, Auchenthaler, Monti, etc., thinks he is justified in arriving at the following conclusions: 1. Tetanus is a disease which is not necessarily fatal. 2. The cause of the disease is febrile or not; in the former case it is but a partial manifestation of general poisoning of the blood; in the latter it consists of reflex spasms excited by peripheric irritation. 3. Prognosis is more favourable in cases unattended by fever, though it is not necessarily unfavourable in cases accompanied by fever. 4. Chloral hydrate is far from being a specific for tetanus, but its employment must be recommended because it is a pure hypnotic, which does not determine congestion of the brain as morphia does, is easily administered to children, and finally has been undoubtedly successful in a great many cases.—*Lancet*, May 30, 1874.

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Lemon-juice in Diphtheria.—M. Revillout recommends (*Gaz. des Hôpitaux*, June 20) in the strongest terms the employment of large quantities of pure lemon-juice as a gargle. He says that he and his father have used it during eighteen years, and always with success, it being the most certain application yet known.—*Med. Times and Gaz.*, June 27, 1874.

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Nature of Fluid Discharged in Coryza.—At a recent meeting of the Société de Biologie, M. Ranvier stated that on examining with the microscope the fluid discharged from the nose at the commencement of coryza, he found that it contained a large quantity of cellular elements, some of cylindro-conical form with a flat surface crowned with cilia, others strongly granular and turgid, in which the flattened surface and cilia had disappeared. Rindfleisch was of opinion that these cells were white corpuscles covered with cilia. It was of great importance to determine if these were really leucocytes, or only deformed epithelial elements. On warming them, some of the cilia could be seen

to recommence their movements, but no amœboid motions were observed. They are, therefore, not white corpuscles of the blood. M. Ranvier has been still more satisfied of this, after examining them in iodized serum. The use of the amniotic liquid of the sheep, highly iodized, enabled him to recognize the fact, in conformity with the statements of M. Bernard, that the white corpuscles of the blood, or the lymph corpuscles, contained considerable quantities of glycogen. In fact, when leucocytes are immersed in iodized serum, they may be seen to acquire a characteristic violet-brown colour. But the cells with vibratile cilia met with in the mucus of coryza, though assuming, indeed, a yellowish tint under the influence of iodized serum, do not give the peculiar reaction of glycogen. It would hence appear to be clearly made out that these are not young elements proceeding from the blood, but that they are the epithelial cells of the mucus.—*Lancet*, June 20, 1874.

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On the Curability of True Croup without Emetics.—Dr. Klemm narrates (*Jahrbuch für Kinderheilkunde*, vol. vi.) a case of croup which was treated by packing in the cold wet sheet. The packing was repeated every three or four hours for the first day or two. The child recovered. Three other cases, similarly treated with the same result, are alluded to. Klemm deems the sweating which accompanies the packing to be not less beneficial than the abstraction of heat. It is important that the treatment should be begun early in the disease, before the false membrane has been abundantly formed.—*London Med. Record*, June 24, 1874.

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On Polypiform Vegetation of the Trachea after Tracheotomy.—Dr. Peter called the attention of the Société Médicale des Hôpitaux, on December 26, 1873 (*L'Union Médicale*), to the details of a case in which tracheotomy had been successfully performed on a child aged three, attacked by croup. The canula could not be removed for three months, as each attempt to do so produced an access of suffocation. Finally it was removed; but it was observed that in any rapid effort, or in attacks of anger or alarm, suffocative dyspnœa was brought on. Finally, in such an attack, the child died suddenly. There was found at the inferior angle of the tracheal cicatrix a polypiform vegetation, incapable itself of giving rise to suffocation and death, but capable of exciting fatal spasm. M. Bergeron related a similar case; and in the course of the discussion which followed many remarkable cases were mentioned, indicating that small growths, at a distance from the vocal cords, are capable of exciting distressing and even fatal accesses of laryngeal spasm; and that sessile granulations at the seat of a tracheal wound require careful attention before the canula is withdrawn after tracheotomy.—*London Med. Record*, Feb. 25, 1874.

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Chloral in the Treatment of Spasmodic Asthma.—Dr. C. Theodore Williams (*Brit. Med. Journ.*, June 13, 1874) speaks highly of the use of chloral in asthma.

In slight cases, he says, it should be administered in doses of twenty to thirty grains once or twice in the night. In severe cases, fifteen or twenty grains should be given every three or four hours until sleep is induced. In by far the majority of instances of neurotic asthma, this treatment has succeeded in allaying the spasms, and in diminishing, or even abolishing, the attacks.

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Double Aneurism of the Thoracic Aorta.—Dr. Theodore Williams exhibited to the Pathological Society of London, May 19, a specimen of double aneurism of the thoracic aorta. The disease was in the descending aorta. The first aneurism was ruptured, and had caused death. The sixth and seventh ribs were eroded. The second projected into the right pleural cavity, and was also eroding. The heart was large, the left ventricle greatly hypertrophied, and the valves diseased. The aorta was much diseased. The upper sac opened into the vessel two inches below the left subclavian by a button-hole aperture; the lower two inches further down by a hole as large as a florin; and the two sacs further com-

municated with each other. The patient, a commercial traveller of thirty-seven, had suffered for years with symptoms of dilatation of the aorta and cardiac enlargement, and at last a pulsating tumour appeared at the left side of the spine, which threatened to burst. Death, however, suddenly took place from internal hemorrhage, with epistaxis. Only three similar cases had been recorded in the *Transactions*.—*Med. Times and Gaz.* June 27, 1874.

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Enemata of Bromide of Potassium in Obstinate Vomiting.—Dr. GIRABETTI has obtained the very best results from the administration of enemata of bromide of potassium, in doses of from one-half to two drachms, in cases of obstinate vomiting attending the pregnant state. The same drug, also administered in enemata, has been very successful in the hands of Dr. Laborde, of Paris, in obstinate vomiting, connected with disease of the stomach, liver, and intestines.—*Lancet*, May 30, 1874.

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On Morbilli Bullosi sive Pemphigoidei.—Dr. STEINER narrates (*Jahrbuch für Kinderheilkunde*, vol. vii.) four cases of measles, attended with an eruption of bullæ. The patients were sisters; and the cases are the only instances of the kind which Steiner has observed out of 6000 of measles. The bullæ appeared on the face, scalp, back, chest, hands, feet, mucous membrane of the mouth, nose, and vulva. The blebs appeared one day after, two days after, at the same time as, and half a day before, the eruption of measles. The bullæ came out in crops, and continued to appear after the measles had ceased. One child, a baby of ten months, died in consequence of pneumonia.—*London Med. Record*, June 24, 1874.

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On Pregnancy with Persistent Hymen.—M. DUFOUR (*Archives de Tocologie*, June, 1874) was consulted by a lady for some abdominal enlargement. On feeling the tumour, the movements of a child were apparent. On proceeding to make a vaginal examination, his finger was prevented from entering the passage by a complete circular band, which ocular demonstration proved to be the hymen. In leucorrhœa the parts sometimes become much relaxed, and rendered thereby very dilatable, so that under certain circumstances the act of coitus may by completed without any rupture of the hymen. In this case the patient said that she had never suffered from the "whites," and this was substantiated by the condition found.—*London Med. Record*, June 17, 1874.

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On Closure of the Uterus by Sutures after Cæsarean Section.—A paper on this subject by Dr. VEIT, of Bonn, was read before the Berlin Obstetrical Society on Oct. 28, 1873. He disapproves of Martin's method of stitching the uterus to the abdominal walls, as tending to produce laceration of both wounds. He considers it most desirable that the uterine wound should be closed. Not only may Lister's catgut sutures be left with impunity in the peritoneal cavity, but also, the knot becoming undone, the stitch falls into the cavity of the uterus to be afterwards discharged with the secretions. Under these circumstances, Dr. Veit describes two cases in which he operated. In the first, he closed the incision in the uterus by means of eight catgut sutures, and the abdominal wound with ten silk ones. The patient recovered without a single bad symptom. In the second instance, seven deep and two superficial catgut sutures were used, the abdominal incision being closed with the material. After many relapses the case ultimately did very well. Dr. Martin related, at the same meeting, the case of a patient convalescing most favourably, in which he had used Veit's plan.—*London Med. Record*, June 17, 1874.

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Oatmeal as Infant's Food.—In a communication to the Société Médicale des Hôpitaux, MM. DUJARDIN-BEAUMETZ and HARDY make known the results of the employment of oatmeal on the alimentation and hygiene of infants. According to them, oatmeal is the aliment which by reason of its plastic and respiratory elements makes the nearest approach to

human milk. It also is one of those which contains most iron and salts, and especially the phosphate of lime so necessary for infants. It also has the property of preventing and arresting the diarrhœas which are so frequent and so dangerous at this age. According to the trials made by M. Marie, infants from four to eleven months of age fed exclusively upon Scotch oatmeal and cow's milk thrive very nearly as well as do children of the same age suckled by a good nurse. —*Gazette Méd.*, April 4, *Med. Times and Gaz.*, April 18, 1874.

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Detection of Alcohol in Organic Fluids. —It is generally difficult to detect alcohol in organic fluids on account of the small quantity of liquid usually available, and the absence of a special reactive. M. BERTHELOT has discovered a very valuable reaction. When placed in presence of water, cold or tepid, benzoic chloride ($C_{14}H_5ClO_2$) decomposes very slowly. But if alcohol is added, benzoic ether is immediately formed, and precipitates into the chloride in excess. The presence of the ether becomes manifest when a few drops of the liquid are treated with a solution of caustic potash; the chloride alone is dissolved, and the ether remains untouched. This reaction is very marked with a liquid containing 1 per cent. of alcohol, and permits the chemist to dispense with distillation.—*Lancet*, June 20, 1874, from *Tribune Médicale.*

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Motor and Sensory Nerves.—In 1863 M. VULPIAN contended that the filaments of the sensory and motor nerves perform the same function, and that their physiological properties were not radically different. He based this opinion upon the following experiment. The hypoglossus (motor) and the lingual (sensory) having been cut, the central end of the lingual was connected by a suture with peripheral end of the hypoglossus. Three months after this M. Vulpian laid bare the central segment of the lingual, separated it from the brain by section, and irritated the stump of the lingual prolonged by the hypoglossus. The operator provoked distinct movements in the corresponding half of the tongue, and then concluded that a sensory nerve can act as a motor nerve under certain circumstances. But M. Vulpian has lately given up this view, and freely confesses his error. He ascertained that one of the branches of the chorda tympani which arises from the facial (which is a motor nerve) accompanies the lingual during its distribution to the tongue. Hence it cannot be maintained that the movements excited in the first experiment were entirely dependent on the action of the hypoglossus. By further trials M. Vulpian found that the chorda tympani is solely concerned in the movements obtained after the connection artificially brought about between the lingual and hypoglossus.—*Lancet*, April 18, 1874.

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Death from Chloroform.—Mr. J. T. CLOVER reports (*Brit. Med. Journ.*, June 20, 1874) a case of death from chloroform occurring in a patient of Mr. John Marshall to whom the anæsthetic was given prior to the removal of some adenoid growths from the posterior nares.

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British Medical Association.—The forty-second annual meeting of the British Medical Association will be held at Norwich, on August 11, 12, 13, and 14, under the Presidency of Edward Copeman, M.D., Senior Physician to the Norfolk and Norwich Hospital. The address in Medicine will be delivered by Dr. Russell Reynolds, that in Surgery, by William Cadge, Esq., and in Obstetrics, by Dr. Matthews Duncan.

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International Medical Congress.—This body will meet at Brussels from September 19 to September 26, 1875, and a committee has been organized to make the necessary preparations. It consists of M. Vleminckx, President of the Academy of Medicine, and the three Vice-Presidents, MM. Deroubaix, Bellefroid, and Crocq, together with M. Warlomont, who acts as secretary.

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University of Vienna.—It is announced that Prof. ROKITANSKY is about to retire from the chair of Pathology in this University. Prof. Von Recklinghausen, of Strasburgh has been invited to become his successor.